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10 **BEFORE THE**
11 **BOARD OF REGISTERED NURSING**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the Accusation Against:

Case No. 2009-210

14 **JOAN MARIE McNEILL, AKA**
15 **JOAN MARIE McNEILL-SPANGLER**
7164 Batista Street
San Diego, California 92111

A C C U S A T I O N

16 Registered Nurse License No. 469679

17 Respondent.
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19 Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

20 **PARTIES**

21 1. Complainant brings this Accusation solely in her official capacity as the
22 Executive Officer of the Board of Registered Nursing ("Board") Department of Consumer
23 Affairs.

24 **Registered Nurse License**

25 2. On or about August 31, 1991, the Board issued Registered Nurse License
26 Number 469679 to Joan Marie McNeill, also known as Joan Marie McNeill-Spangler
27 ("Respondent"). The registered nurse license expired on January 31, 2009 and
28 is currently delinquent.

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2 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible
3 entries in any hospital, patient, or other record, pertaining to the substances described in
subdivision (a) of this section.

4 8. Business and Professions Code section 4060 states, in pertinent part:
5 No person shall possess any controlled substances, except that furnished to a
6 person upon the prescription of a physician, dentist, podiatrist, optometrist,
veterinarian, or naturopathic doctor....

7 **COST RECOVERY**

8 9. Code section 125.3 provides, in pertinent part, that the Board may request
9 the administrative law judge to direct a licensee found to have committed a violation or
10 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation
11 and enforcement of the case.

12 **DRUGS**

13 10. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled
14 substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a
15 dangerous drug under Business and Professions Code section 4022 in that under federal or state
16 law, it requires a prescription.

17 **FACTS**

18 11. On March 1, 2007, Respondent was employed as a registered nurse for
19 PRN Nursing, APC., a nursing registry. On March 1, 2007, Respondent provided nursing
20 services in the Emergency Department of Paradise Valley Hospital in National City, California,
21 and was scheduled to work the 11:00 A.M. to 7:00 P.M. shift.

22 12. On March 1, 2007, at about 4:30 P.M., (1630 hours) P.T., R.N., the
23 Manager of Emergency Services at Paradise Valley Hospital contacted Respondent's employer,
24 PRN Nursing and advised its owner, N.F., that Respondent was bumping into walls and had
25 slurred speech while on duty. N.F. requested a drug screen be performed on Respondent by
26 Paradise Valley Hospital and N.F. advised P.T. that she would attempt to contact Respondent's
27 husband to have her picked up.

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1 13. At about 4:37 P.M. (1637 hours) on the same day, G.D., R.N., the former
2 Director of Emergency Services at Paradise Valley Hospital, also received a call from P.T. P.T.
3 advised G.D. that Respondent appeared to be under the influence of alcohol or drugs while on
4 duty. G.D. responded to the call. Upon arriving in the Emergency Department, G.D. found
5 Respondent in a room and observed Respondent staggering and exhibiting slurred speech and
6 uncontrolled eye tracking. Respondent was not able to remain seated without falling forward.

7 14. At the request of Respondent's employer, and with Respondent's consent,
8 two drug screens were performed on March 1, 2007. The first drug screen was inconclusive
9 because the sample was too cold. The second drug screen from a sample taken from Respondent
10 at about 5:30 P.M. revealed the presence of Hydromorphone in Respondent's system (6390
11 NG/ML-120 mg/ml), but was negative for Hydrocodone and Oxycodone.

12 15. While waiting for Respondent's husband and after the second drug screen,
13 Respondent handed G.D. an empty vial of Dilaudid saying she did not have a chance to dispose
14 of it. Later, an unwrapped syringe fell out of Respondent's scrubs and she subsequently
15 removed two additional unwrapped syringes and a sealed butterfly connector (with needle
16 attached), a blue tourniquet and two pins from her pockets.

17 16. The Omnicell (automated medication dispensing machine) User Reports
18 for March 1, 2007 show Respondent removed the following medications for one of the patients
19 under Respondent's care, Patient 300022217:

- 20 a. Promethazine (Phenergan) 25mg/1 ml INJ at 1:24 P.M..;
- 21 b. Hydromorphone (Dilaudid) 2 mg/1ml 1 ml SYR at 1:24 P.M.; and,
- 22 c. Hydromorphone (Dilaudid) 2 mg/1ml 1 ml SYR at 2:58 P.M..

23 17. Patient 30022217's medical chart shows Physician Orders for Dilaudid (2
24 mg) and Phenergan (12.5 mg) at 1:20 P.M. (1320 hours). These Orders were marked "Done".
25 There was no Physician's Order for the dose of Dilaudid that Respondent withdrew at
26 approximately 2:58 P.M. There was no record that this medication was properly wasted nor
27 returned to the dispensing system.

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1 18. The Nurses Notes show an entry for administration of Phenergan (12.5
2 mg) and Dilaudid (12.5 mg) at 1:00 P.M. The notes indicate these medications were "held" and
3 then "given 11:15". There are two subsequent entries in the Nurses Notes at an undecipherable
4 time for Dilaudid (amounts illegible) indicating these two dosages were "given 1900".

5 19. On March 1, 2007, when G.D. came to the Emergency Room in response
6 to the call from P.T., Respondent denied being impaired and attributed her behavior that day to
7 her blood sugar being "off" and then to exhaustion. The next morning, in a telephone call to her
8 employer, Respondent explained her behavior by stating she had been experiencing severe back
9 pain and that she had used a Fentanyl patch the morning of March 1st and had taken 6
10 Oxycodone by 2 P.M. on March 1st.

11 20. Respondent did not have prescriptions for the Fentanyl or Oxycodone on
12 March 1, 2007.

13 21. Respondent later admitted to removing a 2mg dose of Dilaudid (2 1-ml
14 syringes) from the Emergency Room Omnicell dispensing machine and self-administering a 1-
15 ml syringe to relieve back pain she stated she was experiencing, and then destroying the second
16 1-ml syringe. A short time later, Respondent admitted that she removed the prescribed dose for
17 the patient but before she could administer it, the patient was moved out of the emergency room
18 and she was unable to properly waste that dose.

19 **FIRST CAUSE FOR DISCIPLINE**

20 **(Obtaining and Self-Administering Controlled Substance Dilaudid in Violation of Law)**

21 22. Respondent is subject to discipline under Code section 2761, subdivision
22 (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a),
23 by obtaining and administering controlled substances. The circumstances are that on or about
24 March 1, 2007, while on duty as a registered nurse at Paradise Valley Hospital, National City,
25 California, Respondent obtained the controlled substance Dilaudid for her own use, by taking the
26 drug from hospital supplies and self-administering it as described more particularly in
27 paragraphs 12-21 above.

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Using the Controlled Substance Dilaudid to an Extent or in a**
3 **Manner Dangerous or Injurious)**

4 23. Respondent is subject to discipline under Code section 2761, subdivision
5 (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in
6 that on or about March 1, 2007, Respondent used the controlled substance Dilaudid to an extent
7 or in a manner dangerous or injurious to herself, any other person, or the public or to the extent
8 that such use impaired her ability to conduct with safety to the public the practice authorized by
9 her license, as described more particularly in paragraphs 12-21 above.

10 **THIRD CAUSE FOR DISCIPLINE**

11 **(Falsifying, Making Grossly Incorrect Entries)**

12 24. Respondent is subject to discipline under Code section 2761, subsection (a)
13 for unprofessional conduct, as defined in section 2761(e) in that Respondent made a false, grossly
14 incorrect, grossly inconsistent, and unintelligible entries in Patient 30022217's medical chart as is
15 more particularly described in paragraphs 16-18 above.

16 **PRAYER**

17 WHEREFORE, Complainant requests that a hearing be held on the matters herein
18 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- 19 1. Revoking or suspending Registered Nurse License Number 469679, issued
20 to Joan Marie McNeill, also known as Joan Marie McNeill-Spangler;
21 2. Ordering Joan Marie McNeill, also known as Joan Marie McNeill-Spangler
22 to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement
23 of this case, pursuant to Code section 125.3; and,

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3. Taking such other and further action as deemed necessary and proper.

DATED: 3/23/09


RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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